

Case Number:	CM15-0199292		
Date Assigned:	10/19/2015	Date of Injury:	10/04/2013
Decision Date:	12/22/2015	UR Denial Date:	09/25/2015
Priority:	Standard	Application Received:	10/09/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Illinois, California, Texas
Certification(s)/Specialty: Orthopedic Surgery

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 57-year-old female who sustained an industrial injury on 10/4/13. Injury was reported relative to lifting a grocery bag. She was diagnosed with left shoulder impingement syndrome. The 4/8/15 left shoulder MRI documented a laterally downsloping flat acromion, acromioclavicular joint osteoarthritis, partial thickness tears of the supraspinatus and infraspinatus tendons, synovial effusion, subacromial subdeltoid bursitis, SLAP tear, and partial thickness biceps tendon tear. The 9/16/15 treating physician report cited intractable severe shoulder pain with profound limitation. A positive diagnostic injection test was documented. Left shoulder range of motion was documented as flexion 140, extension 30, abduction 135, external rotation 90 degrees, and internal rotation to L4. Hawkin's, cross chest, AC joint compression, Yergason's, and dynamic shear tests were positive. She had failed conservative treatment including activity modification, medications, physical therapy, chiropractic, massage, and injection. Authorization was requested for left shoulder arthroscopic acromioplasty with distal claviclectomy, 12 visits of post-op physical therapy, and associated surgical items including abduction brace, pain pump, purchase of a cold therapy unit, and 21-day rental of a continuous passive motion (CPM) machine. The 9/25/15 utilization review certified the request for left shoulder surgery and post-op physical therapy. The request for an abduction brace was non-certified as the injured worker was not undergoing a large and massive rotator cuff repair. The request for pain pump was non-certified as guidelines do not recommend pain pumps. The request for a cold therapy unit purchase was modified to 7-day rental consistent with the Official

Disability Guidelines. The request for 21-day rental of a CPM machine was non-certified as there was no documented adhesive capsulitis.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Associated Surgical Service: Abduction brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Postoperative abduction pillow sling.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Activity Modification, Summary. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Postoperative abduction pillow sling.

Decision rationale: The California MTUS guidelines state that the shoulder joint can be kept at rest in a sling if indicated. The Official Disability Guidelines state that post-operative abduction pillow slings, are recommended as an option following open repair of large and massive rotator cuff tears. Guideline criteria have not been met. An arthroscopic rotator cuff repair is planned for a partial thickness tear. Guidelines generally support a standard sling for post-operative use. There is no compelling reason to support the medical necessity of a specialized abduction sling over a standard sling. Therefore, this request is not medically necessary.

Associated Surgical Service: Pain pump: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Postoperative pain pump.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Postoperative pain pump.

Decision rationale: The California MTUS guidelines are silent regarding this device. The Official Disability Guidelines state that post-operative pain pumps are not recommended. Guidelines state there is insufficient evidence to conclude that direct infusion is as effective as or more effective than conventional pre- or postoperative pain control using oral, intramuscular or intravenous measures. Three recent moderate quality randomized controlled trials did not support the use of pain pumps. Given the absence of guideline support for the use of post-operative pain pumps, this request for pain pump purchase is not medically necessary.

Associated Surgical Service: Purchase of a cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Continuous passive motion (CPM).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Continuous-flow cryotherapy.

Decision rationale: The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The use of a cold therapy unit would be reasonable for 7 days post-operatively. However, this request is for an unknown length of use which is not consistent with guidelines. The 9/25/15 utilization review decision recommended partial certification of a cold therapy unit for 7-day rental. There is no compelling reason in the medical records to support the medical necessity of a cold therapy unit beyond the 7-day rental already certified. Therefore, this request is not medically necessary.

Associated Surgical Service: Twenty one day rental of a continuous passive motion machine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Continuous passive motion (CPM).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Continuous passive motion (CPM).

Decision rationale: The California MTUS are silent regarding continuous passive motion (CPM) units. The Official Disability Guidelines do not recommend CPM units for rotator cuff problems. These units are recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. Guideline criteria have not been met. There is no clinical evidence suggestive of adhesive capsulitis. The injured worker has been certified for an acromioplasty with distal clavicle excision. There is no compelling rationale presented to support the medical necessity of this unit in the absence of guideline support. Therefore, this request is not medically necessary.